

Failure: Too Quick to Judge

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Performance has been the hallmark within the workplace of productivity for some time. However, critical reflection of failures has been the precursor to improvements since before history was recorded. The process of critically analysing something that was considered a failure involves identifying, questioning and assessing the deeply held assumptions about the knowledge of something that failed.

In 1912, the Titanic set off on its maiden voyage. During the voyage an iceberg was identified by the crew's nest spotter but he failed to identify the true size of the ice rock, which led to the demise of the iconic vessel. At the time this was seen as a devastating failure with a massive loss of life and a devastating financial loss of the world's largest cruise liner at the time. However, in 1916 with the failure of the Titanic in mind, Paul Langevin developed a theory of bouncing sound waves off objects under water as detection method. This was later referred to as sonar with the first working model created in 1917. Today sonar technology is used widely across the world in many different applications from collision avoidance systems in submarines, ocean exploration, to collision avoidance in personal motor vehicles. Furthermore, the sinking of the unsinkable ship sparked a flurry of engineering investigation in the ship construction industry, leading to many policies that are still used today. Although the sinking of the Titanic was a devastating failure, there is no way of measuring the positive impact of the development of sonar and ship construction policies have had on society. This principle can be applied on much smaller scales in the workplace also.

The word failure is thrown around in the workplace as if it is a factual statement of an outcome that wasn't what was required. However like the Titanic example, one could argue that this view may be too narrow or too anchored to a particular timeframe to be a true statement. Before our Air Force can be 'safe-to-fail', we need to rethink the way the word is used.

Stigma of Failure

Within the Air Force today, failure is considered a negative outcome. The stigma associated with it tends to bring a level of embarrassment and a potential loss of social status within the workplace. Evolutionary psychologists provide a potential explanation for this, as it may relate to the way our brain developed socially thousands of years ago. Within a small tribe, typically when a person failed it have grievous consequences on the individual or the tribe. This may have mean the tribe couldn't rely on that individual to perform their role. At this period of human development, there was little tolerance for individuals that couldn't contribute to the tribe. This would often lead to the tribe cutting the dead weight. Our brains still see this as a potential result of failure, leading to our often disproportionate negativity around it. In today's workplaces, failing to achieve a deadline or task to completion can have flow on effects. However, not all failures have consequences as large as they are perceived.

Psychological Safety

A more recent topic of interest in the workplace is the concept of psychological safety. Although there are many differing definitions of the concept, most revolve around Edmonds 1999 definition of having a shared belief of safety to engage in interpersonal risk-taking within the workplace. Although the concept of psychological safety is designed to reduce failures through open and effective communication of team member, people within such a workplace seem more willing to admit failures. A psychologically safe workplace also accommodates critical thinking and constructive communication, which is a key aspect when learning from failures. Therefore, there may be a negative correlation between psychological safety and stigma of failure within the workplace. There may also be a positive correlation between psychological safety and constructive lessons learnt from a perceived failure. Furthermore, a workplace with a high level of psychological safety may not perceive things as a failure but a series of shortfalls and lessons learned. The passage of time may also lend a hand in seeing things as a learning opportunity rather than a failure, as I have experienced in my career.

The Set Up

Many years ago I was the supervisor of an aircraft load team on an exercise. During the exercise, we had been working long and strenuous days. Toward the end of the week, my team was looking increasingly fatigued and the spring in their step had faded. On the tail end of the week, there was a last minute change to the weapons and configuration required for a mission. This meant several aircraft needed to be downloaded, reconfigured, tested and reloaded after having just loaded them.

The Failure

One by one team members' emotional inhibitions gave way allowing their frustrations to bleed out into the world. One piece of alternate mission equipment was dropped and damaged beyond the repair capability of maintenance facilities on the exercise. One of the testing requirements were initially misinterpreted (by me) forcing a test/retest situation to rectify the issue. Which caused the aircraft to be late to come online forcing them to abandon the mission. Ultimately, the pilots failed to make it 'on time on target', which was perceived as the only important factor. However, this view fails to take in the whole picture of the events and the follow on effects.

Broadening the Picture

What the typical view of the event fails to take into account are a little less measurable follow on effects, much like the invention of sonar. Firstly, the aircrew gained a better idea of the time required for a reconfiguration change, but more importantly, that not all reconfiguration changes are equal. After making the mistake on the testing requirements, for the rest of the time on that platform I didn't made the mistake again, with that system or any other system I worked on. As a supervisor I gained valuable experience in leading a fatigued team through stressful situation. Also, I saw clearly the breaking points of each of my team members and was able to use and pass on that knowledge of how much stress can be applied to particular individuals before they buckle.

Furthermore, the event turned out to be a huge bonding exercise for the crew, members shared their perspective of the event over drinks for the following months. When all things are considered and I am sure I am still missing many more variables and the event doesn't seem as much of a failure as what was perceived at the time.

Summary

Becoming 'safe-to-fail' may be far more complex than a cultural change suggested by the theory of psychological safety, not to discredit how challenging changing culture is. But changing the way we see failure may be changing the very neuro chemistry that is hardwired into our minds that intertwines with the way we

socialise. However, each failure contains a wealth of potential lessons, highlighting the importance to allow some level of failure. Therefore, delaying judgment of an event to take in the bigger picture is important for us to adopt. Ironically, we may fail but persistence will be important, as nothing worth doing is easy.